S.C. SECOND INJURY FUND REIMBURSEMENT REQUEST FORM

Mail To:

SECOND INJURY FUND OPERATIONS
POST OFFICE BOX 12349
COLUMBIA, S.C. 29211

PLEASE REVIEW INSTRUCTIONS ON REVERSE SIDE

Second Injury Fund No.	
Carrier No.	
Date of Accident	
Compensation Rate	
Carrier	

Employee: Employer:	
Date of first payment of compensation:	Date for 100% Medical Reimbursement: *(1st Day of 79th Week after accident)*

Type of Comp Paid	Date Beginning	Date To	Weeks	Amount
TEMPORARY TOTAL				
TEMPORARY PARTIAL				
PERMANENT PARTIAL				
PERMANENT TOTAL				
DEATH OR OTHER *(SPECIFY)*				
		TOTAL INDEMNITY TO DATE		
LESS 78 WEEKS		**WEEKS** / **AMOUNT**		
	Wks at Full Compensation Rate			
	Wks at Temporary Partial Rate			
		NET REIMBURSABLE INDEMNITY REIMBURSEMENT		
LESS ANY PRIOR INDEMNITY REIMBURSEMENT				
TOTAL INDEMNITY REIMBURSEMENT REQUESTED				
TOTAL MEDICAL REIMBURSEMENT REQUESTED *(ENCLOSED ITEMIZED LIST - SEE INSTRUCTIONS)*				
TOTAL REIMBURSEMENT REQUESTED				

I hereby certify, that to the best of my knowledge and belief, the information as indicated above is true and correct as of this date: _____

MAIL REIMBURSEMENT TO:

_____
NAME

_____
ADDRESS

_____

_____
NAME OF CARRIER OR EMPLOYER, IF SELF-INSURED

SIGNED BY _____

TITLE _____ DATE _____